MINISTRY OF HEALTH

Central Health Services Council

STANDING MENTAL HEALTH ADVISORY COMMITTEE

The Training of Staff of Training Centres for the Mentally Subnormal

Report of the Sub-Committee

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Training the Mentally Subnormal

The Report is published today of the Committee (Chairman Dr. J. A. Scott, Medical Officer of Health, London County Council) appointed in September, 1959, "to advise on the training of staff in training centres for the mentally subnormal, provided by local health and hospital authorities, and on the number of staff required". Its main recommendation is that two year training courses should be provided under a Central Training Council.

When the Report came before the Central Health Services Council, the Council recorded their view that, while the Report was a most valuable contribution to the study of the problem, lack of agreement about the nature of the training courses and a shortage of suitable candidates made it unrealistic to expect that the recommendations could be fully and immediately implemented. The Council therefore advised the Minister of Health that further research is needed and that there should be one or more pilot schemes to provide information on which subsequent developments could be more firmly founded.

The Minister, in consultation with the Minister of Education, is now seeking the views of interested bodies.

MINISTRY OF HEALTH,
SAVILE ROW,
LONDON, W.1.

13th July, 1962

PREFACE

1. This report of the Sub-Committee on the Training of Staff of Training Centres for the Mentally Subnormal, appointed by the Standing Mental Health Advisory Committee, came before the Central Health Services Council in accordance with the procedure laid down in Section 2 of the National Health Service Act, 1946.

2. The Council recorded their view that, while the report was a most valuable contribution to the study of the problem, it was unrealistic to expect that the recommendations could be fully implemented immediately because of the lack of any agreement on the orientation and content of the course and of the unlikelihood that a sufficient number of suitably qualified teachers would be quickly attracted to this field.

3. The Council, therefore, advised the Minister that, recognising the need for further research which might bring more closely in line the divergent expert views which had been expressed, one or more pilot schemes should be started which would yield useful information on which to found subsequent developments.

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GENERAL INTRODUCTION

1. We were appointed in September, 1959, to advise on the training of staff in training centres for the mentally subnormal provided by local health and hospital authorities and on the number of staff required. In January, 1960, we advertised our appointment in the press, inviting interested bodies to submit evidence to us. We have been greatly assisted in our task by the considerable number of organisations and individuals from whom we have received evidence, and we take this opportunity of acknowledging our indebtedness to them.

2. We held our first meeting in January, 1960, and we have since met 20 times —on 15 occasions for a full day. At 9 of our meetings we have heard oral evidence. In May, 1960, we issued a questionnaire to 146 local health and 63 hospital authorities seeking information about the number and training of staff employed at 31st December, 1959, and about certain related matters. The information given by these authorities has been most helpful and we are grateful to them for their co-operation.

3. In order to give ourselves a deeper appreciation of the nature of our problem and its solution we have visited the centres (or schools) of 12 local authorities, 5 hospitals and 2 voluntary organisations. Each of these visits has been interesting. Many of them have been stimulating. We have been glad of the opportunity of meeting the staff, of seeing them at work, and of hearing their views on their work and the training required for it. Our thanks are due to many people on account of these visits, both for willing help and for hospitality.

I. THE TRAINING OF STAFF

Historical Introduction

4. In 1904 the Royal Commission on the Care and Control of the Feeble-Minded was appointed to consider the needs of the feeble minded and other mentally disordered persons who were not considered certifiable under the Lunacy Acts, and the need for special forms of treatment for them and for idiots. The Commission's report was published in 1908 and was followed in 1913 by the enactment of the first Mental Deficiency Act, which imposed on local authorities the obligation to make suitable provision for defectives in their area. In the meantime the first centre for the occupation of mental defectives outside a hospital was founded by a voluntary association in London in 1909. After the passing of the Mental Deficiency Act, 1913, the Central Association for the care of the Mentally Defective, working closely with the Board of Control, stimulated interest in mental deficiency work throughout the country, and further centres began to be set up, but despite a 50% exchequer grant local authorities did not show much interest. The Mental Deficiency Act, 1927, however, made it the duty of local authorities to provide suitable training or occupation for defectives who were under supervision or guardianship, or had been sent to certified institutions, and thereafter the number of local authority centres began to rise more quickly. At the same time the number of centres run by voluntary associations began to decrease. By 1938 there were some 60 local

authority and 95 voluntary centres. Together they provided for about 4,000 defectives.

5. The 1939-45 war period led to a falling off in this provision, and financial difficulties in the early years of the National Health Service led to a slow post-war start. The principle of local authority responsibility was by this time, however, generally accepted and the process of taking over voluntary centres and building new ones proceeded steadily. By 31st December, 1959, there were 435 local authority and 20 voluntary centres and the numbers covered had increased to about 17,500. This expansion of the local authority training centre service was stimulated by the report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, which was published in 1957. The Commission stated as one of its general principles for the future that there should be a reorientation in the mental health services away from institutional care when the special facilities of the hospital service are not needed and towards care in the community. Following the report of the Royal Commission the provision by local health authorities of training centres for the mentally sub-normal has become a duty under Section 28 of the National Health Service Act, 1946, and authorities are now empowered under Section 12 of the Mental Health Act, 1959, where necessary and subject to various conditions, to require parents to send their mentally subnormal children to such centres.

6. Our terms of reference assume a similarity between the training centres of local authorities and the centres, traditionally called " schools ", in hospitals but this has not always existed and does not exist to-day in every respect. Although not all hospitals have " schools ", and training of the type which outside a hospital would be carried out in a training centre is sometimes done on the wards, it is probable that something in the nature of the hospital school has existed since the earliest days of institutions for mental defectives. Yet it would be difficult to arrive at a practical definition of a hospital school. Hospitals vary greatly in size, situation and tradition. Any separate building to which the young severely subnormal in hospital go for day time occupation may be called " the school ".

7. The patients attending hospital " schools " at present may suffer from different disorders, but the development of educational facilities for handicapped children outside hospital has tended to reduce the number of different kinds of patient in these schools. Special schools are increasingly being provided outside hospital for educationally sub-normal children, i.e. those who, by reason of limited ability or other conditions, resulting in educational retardation, require some specialised form of education, and many children who would now attend these special schools were previously to be found in hospital schools. Nowadays the hospital schools are more like the local authority training centres, and for many years the course of training provided for local authority staff has been considered suitable for some of the staff employed in the hospital schools. Hereafter we shall use the term " centre " to include the hospital " school ".

8. Courses of training leading to Certificates of Proficiency in Mental Nursing and in the Nursing of Mental Defectives were instituted in 1891, and these certificates were granted by the Royal Medico–Psychological Association until

1951. The courses included sections on the teaching of mentally defective children and adults. Before 1918 the Central Association for the Care of the Mentally Defective held courses of lectures relating to mental deficiency and the care and training of mental defectives for officers of local authorities. In 1919 the Association's training courses of six weeks' duration for Supervisors and Visitors of defectives employed by local authorities were approved by the Board of Control, which was prepared to contribute one half of the expenses incurred by the authorities in sending not more than two supervisors in any one year to take the course. In 1922 the Central Association with expanded functions became the Central Association for Mental Welfare, which continued the pioneering work of setting up training courses and led the way in interesting teachers, educational psychologists and doctors in the importance of work with the mentally defective. Training courses suitable for both hospital and local authority staff—for " persons engaged in the training of mental defectives in occupation centres, institutions or mental hospitals " were instituted as far back as 1936. During the 1939-45 war the Association became a constituent body of the Provisional National Council for Mental Health and in 1946 was reformed into the National Association for Mental Health. Since the war there has been much additional stimulus to provision for the mentally subnormal by the National Society for Mentally Handicapped Children.

Existing Training Centre Staff

9. The returns in reply to our questionnaire showed that at 31st December, 1959, 2,149 persons were employed in training centres. This figure consisted of 338 men and 1,811 women and included 124 part time staff. It excluded domestic staff and escorts. 363 persons held the diploma of the National Association for Mental Health; 171 held a nursing qualification; 64 were qualified nursery nurses; 42 were qualified teachers; 14 were occupational therapists; 12 were social workers; and 17 had a trade qualification. Few of the remaining 1,466 held any relevant qualification.

The distribution of the staff according to grade and type of employing authority is shown in Table 1.

Table 1

The distribution of staff at 31st December, 1959

Grade	County Borough Councils	County Councils	Total (Councils)	Hospitals	Grand total
Organiser	2	9	11	2	13
Supervisor	129	219	348	64	412
Deputy or Assistant Supervisor	382	514	896	233	1129
Assistant or Trainee	41	87	128	4	132
Instructor	55	46	101	117	218
Other	46	120	166	79	245
Total	655	995	1650	499	2149

Further information given in reply to our questionnaire is shown in the Tables in Appendices C-G.

Present Training Arrangements

10. It is impossible to consider the present training arrangements without immediately becoming aware of the vital role played in them by the National Association for Mental Health. The activities of the Association have developed over the years and it is now the recognised national training body for staff of training centres for the mentally subnormal. Holders of the Association's diploma qualify for a nationally negotiated salary scale. The diplomas are awarded to students who successfully complete one of the Association's full-time courses lasting one year and satisfy the Association's examiners on their practical and theoretical knowledge and their teaching ability. The Association also runs in-service courses, covering the same syllabus as the full-time course for the staff of junior centres, lasting two years, and leading to the diploma; and in addition runs refresher courses of one week's duration for these staff. The in-service courses are organised from time to time in conjunction with particular local authorities who ask for them.

11. It would be difficult to over-emphasize the value of the contribution made by the National Association for Mental Health to the training centre service. It has enrolled over 700 students in the past fifteen years, and has created standards in a service where few, if any, existed before. In doing so it has built up a body of knowledge, founded on experience, which is of a quality aimed at by all the best pioneering organisations. All this has been achieved in the face of great practical difficulties such as shortage of staff and accommodation and the inevitable financial problems that beset voluntary bodies, but it has not been achieved without a good deal of criticism of the arrangements for the training courses. The Association, however, has made it clear that it is not satisfied with these arrangements and that it is anxious to improve not only the quality of the training but also the conditions under which it is undertaken. Latterly the Association has been aware that its activities in the future might well be affected by our recommendations, but it has not hesitated to give us the benefit of all the advice and help it could, nor to continue to develop its role, nor to promise to continue that role or to modify it, as the case might be, in the light of our recommendations. In short it has behaved, and has given every indication that it will continue to behave, in accordance with the best traditions of voluntary service.

12. The diploma course for the staff of junior training centres is open to both men and women who must ordinarily be between 20 and 40 years of age. The main purpose of the course is to prepare students to be practical teachers whose function is to understand and provide for children and young people who, though limited in ability, are developing and are able to acquire physical, social and expressive skills and to grow in understanding of the world around them. There are no fixed academic standards for admission but students are required to have a good general education, to be of suitable personality, and to be physically fit. They should also have had some experience of handling children. Applicants are selected by the National Association for Mental Health. The course covers three terms, i.e., one academic year. The first and final terms include lectures, discussions, tutorials, practical classes and visits of observation. Visits are made to ordinary schools of all kinds as well as to special schools.

Teaching practice, supervised by a tutor of the course, is carried out in the middle term in selected training centres for the mentally subnormal. The main elements of the syllabus are the principles and methods of teaching; the medical aspects of mental subnormality; child development; child care and health; child management; and legislation and administration. Students who complete the course satisfactorily are eligible to sit for the written examination for the diploma. This is awarded on the results of examinations conducted by internal and external examiners of both theoretical and practical work. Proficiency in the written and theoretical work alone is not considered to be sufficient to merit the award of the diploma. The practical ability of the student in teaching children individually and in groups is considered to be of major importance.

13. The diploma course for the staff of adult training centres is also open to both men and women. The aim of the course, which was introduced in 1960 and runs for one year, is to give teachers and instructors of the mentally subnormal adult theoretical and practical knowledge to enable them to deal with everyday routine problems encountered in their work. Attention is paid to the requirements of the subnormal who are in need of sheltered occupation, but particular emphasis is placed on work habits and the specialised training which will lead to social adjustment within the community. The course is planned on the same general lines as the course for the staff of junior training centres.

14. There is no training on a national scale apart from that provided by the National Association for Mental Health. A number of local and hospital authorities organise local courses for training centre staff, but valuable though these courses are they do not alter the essential pattern that exists at present of training organised nationally by a voluntary body. Our attention has been particularly drawn to two examples of different kinds of local training schemes. The one, organised by the Staffordshire County Council, aims to bridge the gap between the age of recruitment and age 20, when students become eligible to apply for a place on a diploma course, and to provide some training as a preliminary to the Association's diploma course. The other, arranged by the Middlesex County Council, provides training over a period of two years to new entrants aged about 18 years, in lieu of the diploma course. The Middlesex students are given a background to the theoretical and practical aspects of the training of severely subnormal children, and practical work is carried out in schools and training centres. In addition visits of observation are made to other schools and hospitals, to a child guidance clinic and to a juvenile court. There is a qualifying examination at the end of the course. We understand that there would be no objection in principle to the enrolment of students from other authorities on the Middlesex County Council's course.

15. In general the arrangements for refresher courses follow the same essential pattern as for other courses. The National Association for Mental Health provides short refresher courses for staff concerned with the teaching of the mentally subnormal. These have usually been residential courses of one week's duration, and in recent years over 100 students have attended annually. On two occasions in recent years, however, training days in various centres have been organised as an alternative. A number of local and hospital authorities

also provide refresher courses. These are usually shorter courses of a few days duration.

The Needs and Potentialities of the Mentally Subnormal

16. The Mental Health Act, 1959, repealed the Mental Deficiency Acts, and the legal term mental defective then became obsolete. The Act recognises four categories of mental disorder, including subnormality and severe subnormality. It defines subnormality as a state of arrested or incomplete development of mind (not amounting to severe subnormality) which includes subnormality of intelligence and is of a nature or degree which requires or is susceptible to medical treatment or other special care or training of the patient. Severe subnormality is defined as a state of arrested or incomplete development of mind which includes subnormality of intelligence and is of such a nature or degree that the patient is incapable of living an independent life or of guarding himself against serious exploitation, or will be so incapable when of an age to do so.

17. Consideration of the legal definitions in the Mental Health and Mental Deficiency Acts is of little value in assessing the needs and potentialities of the mentally subnormal or their predecessors, the mentally defective. General descriptions of their personal characteristics are more helpful, but even a classic description such as that of Dr. E. O. Lewis, whose investigation into the prevalence of mental deficiency formed a basis for the administrative recommendations of the 1929 Wood Report, though most informative, is of limited value for this purpose. The objectives of the staff of training centres are more relevant and our consideration of these objectives has involved the examination of a variety of views on the needs and potentialities of the mentally subnormal. These views, which have been expressed to us in evidence, have ranged from the view that the mentally subnormal are capable of considerable improvement and that this can be achieved only by a highly and specially trained teacher to the view that there is little that can be expected of them and little training of staff is required. Many intermediate views have been expressed to us. A common feature, however, is that there is great need for further research into the subject. Our attention has been drawn to the research that has already been undertaken, in particular to some of the research into the educational aspects of mental subnormality which suggests that in order to learn mentally subnormal children require more repetition than would be the case with normal children; that memory of material once learned is good even without rehearsal; that symbolic skills such as reading should not be taught until the age of 11 or 12 years and that most older adolescents are still able to learn successfully; that young children under the age of 11 years who are not mongoloid may profit from Montessori aids in learning letters; that the transfer of material once learned is good, so that transfer techniques should be used; and that the severely subnormal need special training in coding, that is the transfer of spoken language into print and vice versa, and special training in verbal fluency and in the relationship between verbal instructions and actions. We recognise the value of this work, but we are convinced that there is great need for more knowledge, in particular of the wider educational aspects of the subject, and we believe that this can be acquired only through research. We appreciate that as the results of this research become available they may affect the recommendations we make about the training of

staff. **We recommend that authorities and staff should be made aware of the need for educational and psychological research on mental subnormality and should be encouraged to co-operate in, indeed to initiate, research whenever a suitable opportunity occurs.**

18. Conflicting opinions have been expressed to us about the extent to which the mentally subnormal can benefit from training, but there is no doubt that the great majority are capable of some learning, although not necessarily of the academic type, and the question whether they should be taught or trained is often asked; simple occupation is clearly not enough. For many people this question has seemed not to arise, because they believe that by definition the mentally subnormal are ineducable. The Mental Health Act, 1959, has, however, in effect substituted the words " unsuitable for education at school " for the words previously in the Education Act, 1944, i.e., " incapable of receiving education at school ", and has thus removed any statutory suggestion of ineducability. The change of words is helpful, but it is no more than a reflection, and not necessarily an accurate reflection, of the facts in the light of the prevailing circumstances. This point will only be clarified by further research, and we have already stressed the need for this. Meanwhile the essential fact is clear. Mentally subnormal children are children. They happen to be subnormal, but we are satisfied that their basic needs are the same as those of other growing children and the question as we see it is not whether they should be taught or whether they should be trained, but what form of education will help them to develop and mature so far as they are able and how far their needs reflect on the training which the teachers themselves should have. We are here using the words " education " and " teachers " in their widest sense and not limiting them, for example, to an academic type of education or to teachers recognised as such by the Ministry of Education.

19. The subnormal learn slowly and the process of educating them is likely to last well into adult life. As they become adult the element of vocational training becomes increasingly important, and ultimately dominant, but there is nevertheless a need for the teacher in the adult centre to continue a great deal of the work of the teacher in the junior centre. The importance of even a limited measure of independent life in the community points to the need for social education in the widest sense. Considerations of this sort suggest that there are no grounds for believing that there is any great change in the needs and potentialities of the mentally subnormal at the age of 16 years, i.e., the age commonly adopted for transfer from junior to adult centres. Transfer to an adult environment is undoubtedly an essential stage in the development of the subnormal, but there should be flexibility in arranging it. In any particular case transfer at an earlier or later age than 16 might be appropriate, or it might be best achieved by gradual assimilation. In any case the continuing need to be taught and the developing need for vocational training suggest that in the earlier years training additional to the training required in junior centres is required in adult centres rather than that there should be a wholly different kind of training, and this clearly implies that the staff of adult centres should have many of the qualifications of the staff of junior centres in addition to the qualifications specially required to meet the needs of the adult subnormal. In the later years the training should be mainly directed to meeting the specifically adult needs

of the mentally subnormal, e.g., the need to feel they are doing something useful for the community. These needs call for facilities such as workshops and for an atmosphere of productivity.

20. We have considered the differences between the mentally subnormal in hospital and in local authority centres. There are undoubtedly many patients in hospital who fundamentally are the same in kind as many of the subnormal in local authority centres, and so far as children are concerned these may form the bulk of those admitted to hospital. There are also many in hospital with distinctive features which demand the attention of the special resources of the hospital, and we recognise that among those who present medical or nursing problems will be some who can benefit from training and others who cannot. We see no reason, however, to suppose that the educational as opposed to the medical and other needs of the mentally subnormal in hospital cannot in general be met in the same way as the similar needs of those in local authority centres.

The Training required by the Staff

21. We discuss in this section of our report our main concern, that is, the training of the majority of the staff. These are the supervisors and deputy and assistant supervisors, for whom in our view it is feasible to devise a common course of training. They may teach in either junior or adult centres. A separate and shorter course is appropriate for the various grades of instructors employed mainly in adult centres (see para. 33).

22. We have examined the syllabuses of the existing training courses in the light of our consideration of the needs and potentialities of the mentally subnormal and we are satisfied that they should in future be orientated more towards giving the student the essential elements of ordinary teacher training, and that this cannot be effectively done by modification of the present courses without extending them beyond one year. **We recommend that courses of two years training should be provided in places approved by a Central Training Council. For the immediate future this would be the main source of supply.** The natural places for many of these courses are likely to be colleges of further education. We set out in Appendix B to our report an outline of the content of the two year course we have in mind for teachers in junior training centres. The National Association for Mental Health has told us that the time has come to suggest that its diploma course should be expanded to two years and we hope that this development, which we regard as desirable and consistent with our proposals, will soon take place.

23. It has been represented to us that all the teachers in training centres should be qualified teachers, i.e., recognised as such by the Ministry of Education. This view reflects the argument that the more difficult the problem presented by the pupil the better the training the teacher should have. The mentally subnormal in training centres are by definition unsuitable for education at school, but it does not follow that they cannot be educated elsewhere. There is in fact no doubt that they respond to proper education by specially qualified teachers with the right personality, and we believe that it is in the interests of the community no less than in the interests of the subnormal that they should be given

such education. The skill and insight of the qualified teacher may well be necessary to determine in what way and to what extent they can be educated and to facilitate the process of this education.

24. If the mentally subnormal can benefit significantly from education by staff with ordinary teacher training to an extent that cannot be achieved by staff with other training there is no doubt that such teachers should be employed in training centres. We have been impressed by the conviction with which some of those who have given evidence to us have maintained that such benefit would be achieved by qualified teachers, and we are satisfied that there is in ordinary teacher training much that is valuable to the teacher of the mentally subnormal. On the other hand it has been made clear to us that the teacher of the mentally subnormal needs to have special knowledge which is not acquired in the course of ordinary teacher training. The question immediately arises whether qualified teachers should receive additional training to fit them for training centre work or whether a course should be devised which includes both the elements of ordinary teacher training useful to the teacher of the mentally subnormal and the special training necessary before work with the subnormal can be satisfactorily undertaken. The answer is not clear cut, but we feel that the introduction into the training centre service of more qualified teachers would be of benefit not only directly to the subnormal but also indirectly in that the service would benefit from the injection of additional professional workers of good academic standing. **We recommend that arrangements should be made with an institute of education to provide, in association with other similar courses, one year supplementary courses for qualified teachers who wish to undertake teaching in training centres.** These courses would be open to university graduates who wish to teach the mentally subnormal, and in general we consider it desirable that a graduate should take such a course before undertaking teaching.

25. The question remains whether a special course of ordinary teacher training length, which would include both the elements of ordinary teacher training useful to the teacher of the mentally subnormal and the special training necessary before work with the subnormal can be satisfactorily undertaken, is required. In our view this is a matter which should be considered further, and **we recommend that consideration be given by a Central Training Council to the introduction in a teacher training college of a specially designed experimental course lasting three years for unqualified staff.** Such a course should be associated through the same institute of education with the one year courses we have recommended and should lead to the recognition of those who have taken it as qualified teachers by the Ministry of Education.

26. We have considered recommending that all teachers in training centres should be qualified to teach in ordinary schools (although, as we have already stated, our main recommendation is that they should undertake a two year course of training). We visualize that such a development may lie in the future, but we recognise that it would not be practicable to make such a recommendation at present. In any case it is not clear that a requirement of this nature is desirable. The results of research may, at a later stage, demand development on these lines, but on the other hand the increasing number of schools for the educationally subnormal must be taken into account. The increase may lead to

an increase in the number of the subnormal retained within the educational system; and, therefore, to a lowering of the general level of ability in training centres and a decrease in the need for staff with ordinary teaching qualifications. Conversely the increasing number of places for the educationally subnormal may be filled by pupils at the other end of the educationally subnormal range, i.e., pupils who at present would attend normal schools.

27. We have already referred to the support given to the refresher courses of the National Association for Mental Health. We believe that the increase in the number of trained staff that will follow if our recommendations are implemented will increase the need for refresher courses. **We recommend that local and hospital authorities should give their staff every encouragement to take refresher courses.** Many authorities will no doubt organise their own.

A Central College

28. Throughout much of the evidence we have examined there has been emphasis on the need for research into various aspects of mental subnormality and we are convinced that there is real need for this research. There is scope for research by individual teachers, particularly university graduates with ability to observe and to formulate the results of their observations; and by enterprising authorities with a well developed training centre service, either alone or in conjunction with other authorities. There is scope for research into a variety of problems, such as sense training; the value of giving the mentally subnormal so-called formal education; and the age at which certain skills are best learnt by them. It is clear that research will be facilitated and its results put to their best use if it has a focal point. The value of such a focal point would be enhanced if it served other purposes, such as providing a centre, especially a residential centre, for training and refresher courses, and the other purposes would be better fulfilled in the more stimulating environment of the wider unit. **We recommend that a residential Central College with research interests should be established and that the two-year training courses we propose as our main recommendation should be provided there, among other places.** The College should also provide refresher courses. It would in our view be desirable that the College should have a governing body on which the various interests in the problems of mental subnormality were represented and that it should be established in the area of the institute of education which would be responsible for the proposed one-year course for qualified teachers.

Qualifications for admission to the Training Course for Staff of Junior Centres

29. The two year course we recommend for the staff of junior centres cannot be successfully undertaken by persons without a reasonable standard of academic ability. Such ability is normally indicated by formal qualifications. We recognise that there are at present many excellent teachers in the training centre service who do not possess any formal academic qualifications, and we do not overlook the over-riding need to recruit persons of suitable personality with practical teaching ability. But in view of the increasing number of pupils offering subjects at ordinary level in the General Certificate of Education examination we consider that in future intending entrants to the service are likely to have ample oppor-

tunity to acquire qualifications of this kind, and we believe that the right candidates will in fact acquire them. We understand that in recent years the National Association for Mental Health has found a higher level of education among the students on the diploma courses, and bearing in mind that at present there are many suitable applicants for places in Teacher Training Colleges who are not placed we see no reason to suppose that suitable candidates for the training centre service will not continue to come forward. In our view, with the exception of English, the subjects in which these candidates are qualified are not of prime importance. **We recommend that a student accepted for two-year training should normally have the General Certificate of Education with not less than three " O " level passes one of which should be English Language.** It is desirable that the students should also have some experience of handling children.

30. We consider that entry to the two-year course we recommend should be possible over a wide age range. It is probably unnecessary to fix an upper age limit for entry. Arrangements should be made to enable students of mature age to take the course; the value of entrants with experience of other walks of life is considerable and authorities would be well advised to recruit them. We have married women particularly in mind, and they are of special value if they have had experience of training centres before, or in the earlier years of, their marriage. The main source of recruitment however is likely to be young persons who have recently left school, and a lower age limit is required. **We recommend that the minimum age of entry to a two-year course should be 18 years of age.**

31. Many young persons will enter the training centre service before the age of 18, and we believe that there are advantages in this. Early entry enables both the student and the employing authority to confirm suitability for the work before a formal course of training is undertaken, and it provides an opportunity of acquiring valuable preliminary experience. **We recommend that local and hospital authorities, perhaps in conjunction as may be locally convenient, should establish trainee schemes for school leavers between 16 and 18 years of age, with a day a week release for further education.** Such schemes would bridge the gap before formal training begins and would provide opportunities of employment for suitable school leavers who might otherwise be diverted from the service.

Qualifications required by Staff of Adult Centres

32. We have already suggested that the staff of adult centres should have many of the qualifications of the staff of junior centres. This follows from the need to continue and develop in the adult centre those aspects of education suitable for the older mentally subnormal child. The special problems involved in the handling of the subnormal adult, however, demand staff with additional qualifications or additional staff with other qualifications. Many mentally subnormal adults are capable of the simpler type of repetitive industrial work and can thereby earn money and achieve a more satisfactory role in life. Such industrial work by its more realistic nature is of greater training value than some traditional types of occupational activities and helps some of the subnormal to graduate to outside employment. The creation of an industrial atmosphere in adult centres means that many of the staff required are probably best recruited

from men and women with experience of such conditions. Skilled workers including craftsmen of various kinds are required.

33. The expansion that is currently taking place in the provision of adult training centres depends to a great extent on the recruitment of adequate staff. We visualize that recruits to the service will be drawn from a variety of sources and that a variety of training courses will be required to meet their training needs. It will not be necessary for all these staff to undertake a two-year training course, but a two-year course on the lines of that recommended will be required by some of them, and these students will necessarily have to be qualified by age and education in a way similar to the staff of junior centres. **We recommend that a Central Training Council should consider introducing suitable shorter courses for other staff.** In some cases a conversion or supplementary course will be appropriate. In others a refresher course may suffice.

Exemptions from Training

34. We have not fixed an upper age limit for entry to a two-year training course, and although the returns in answer to our questionnaire show that of 412 supervisors of training centres only 193 hold the diploma of the National Association for Mental Health, we do not suggest that it is necessary for the older or more experienced members of the existing staff to undertake such training. We are well aware that many of the supervisors who have no formal qualifications are nevertheless excellent teachers and supervisors. In our view unqualified members of the teaching staff who have 10 years' experience and satisfactory service should be regarded as qualified and recognised accordingly but should continue to take appropriate refresher courses. Staff with less than 10 years' experience but not less than 5 might take a special shortened course, with special reference to teaching methods, leading to a qualification equivalent to that attainable by staff who undertake a two-year course. The length and details of the shortened course should be settled by a Central Training Council.

35. The information given by local and hospital authorities as a result of our questionnaire shows that the staff of training centres hold a variety of qualifications apart from the diploma of the National Association of Mental Health, e.g., the returns of staff employed by local authorities included 45 State Registered Nurses or State Certified Midwives and 60 Nursery Nurses, and the returns of hospital staff included 19 fully qualified teachers. We suggest below that a Central Training Council should consider such qualifications and decide which could be regarded as exempting or partly exempting the holders from the need to take further training.

A Central Council

36. One of the functions performed by the National Association for Mental Health in its pioneer role is that of national training body. We consider that the training centre service has now reached the stage in its development when it is no longer appropriate for training arrangements to be in the hands of a voluntary body, excellent though that body may be. **The establishment, maintenance and development of higher national standards of training should be supervised by a**

permanent, independent body financed from public funds, and we recommend that a Central Council should be established for these purposes. The members of the Council should be drawn from bodies interested in mental subnormality including the Ministries of Education and Health, local authorities, the National Association for Mental Health and field workers. We understand that legislation would probably be necessary to set up such a Council and we urge that this should be introduced with the minimum of delay. We see no reason why the implementation of other of our recommendations should await the introduction of any necessary legislation.

37. The Central Council we propose would have many functions. One of the first would be to approve colleges and other bodies which would undertake the responsibility for organising courses of training and conducting examinations in which external examiners would participate. The Council would no doubt consider the qualifications of existing staff and decide what qualifications could be regarded as exempting or partly exempting existing teachers from the need to take a two-year course of training. It would award certificates of qualification to students who satisfied the examiners after successfully completing a course of training. A problem for consideration by the Council would be the question of the employment by local and hospital authorities of unqualified staff. It might fix a date some years hence after which authorities should not engage unqualified staff except those with the serious intention of becoming qualified within a specified period and should not retain such staff in the capacity in which they were engaged if they had not become qualified within that period. The Council would initiate and co-ordinate research, and in the light of this would review and promote further developments in the training arrangements. We have recommended that the Council should consider a three-year experimental course recognised by the Ministry of Education for unqualified staff. The general introduction of such a course would be a major step towards securing interchangeability between teachers in training centres and in schools. This interchangeability has been advocated in evidence we have examined on the grounds that it would benefit both services. No doubt the Council would foster a variety of other courses to meet the needs of other groups.

38. For the efficient discharge of its functions the Council should have an advisory staff of experts in various aspects of mental subnormality. They would keep in close touch with training centres by frequent visits. Such visits are an essential element in the development of the service and would be of great value to the staff of centres.

Staffing Standards

39. In Part II of our report we discuss the second part of our terms of reference—the number of staff required. The discussion is mainly in terms of total numbers and annual intakes, but these inevitably depend on the size of the training centre unit, i.e., on the number of the mentally subnormal that can be satisfactorily taught by a single teacher. The appropriate size of this unit is by no means clear, but this is a matter which may be clarified as a result of research. We note that in circular 22/60, issued on 13th September, 1960, the Minister of Health cancelled circular 91/49, dated 26th September, 1949, which

suggested ratios of pupils to staff for centres of various sizes. No general guidance was offered in lieu. Local authorities were informed that the Minister's officers would be glad to advise, if so desired. At a time when untrained staff are being replaced by trained staff and the objectives of the staff are changing; when the training of the staff is itself in transition; and when many of the old or makeshift premises in which the subnormal have for years been taught under most difficult conditions are being replaced by purpose built centres—it seems to us that in these circumstances nothing but the most general guidance can be offered, except in a particular case. Detailed guidance could well be misleading. **For junior centres we recommend that the ratio of teaching staff to pupils should be of the order of 1 : 10, trainee teachers being regarded as supernumerary.** We understand that this ratio is in fact already adopted by a number of authorities, and it is clear from the evidence we have examined that it is widely acceptable among others.

40. We emphasise that this ratio of 1:10 is one of teaching staff to pupils on the register. It takes no account of the team of specialists—psychiatrists, psychologists, speech therapists, social workers, etc.—which should be available to support the staff having the day-to-day care of the subnormal in training centres. It is perhaps a common feature of hospital organisation that this team is avilable, but it is by no means always available in the case of the local authority centres. The success of training, indeed of community care of the mentally subnormal, is jeopardised by failure to devote the proper resources to the task, and we urge local authorities to give serious consideration to the provision of this specialised support for their training centre staff.

41. Our recommended ration of 1:10 is no more than a general guide, and is applicable to junior rather than adult centres; in the latter, instructors may replace teachers, and an instructor in an adult centre may satisfactorily handle a larger group than a teacher in a junior centre. The level of ability of the group is however a relevant factor, and the appropriate size of any group tends to diminish as the level of ability drops. Whatever the appropriate size of the group, we believe that as the number of groups in a centre increases it becomes increasingly necessary to free the supervisor from direct responsibility for a particular group. We **recommend that the supervisor of a centre, whether junior or adult, training upwards of 50 of the mentally subnormal should be free of responsibility for a group or class.** Supervisors of smaller centres should have sufficient time free for administrative work, interviews and supervision of other staff.

Hours and Holidays

42. A further matter affecting the consideration in Part II of our report of the number of staff required, although by no means affecting it to the same extent as the ratio of pupils to staff, is the question of hours and holidays. We obtained a good deal of information on this as a result of our questionnaire and in the course of our examination of the other evidence we received. So far as hours are concerned it is clear that the most common arrangement is for centres to be open for something approaching to school hours. The holiday arrangements, however, are more varied, particularly as between local authority and hospital centres, and this is no doubt due in part to the different conditions of service of

staff in different parts of the National Health Service. It is noticeable that there is also variety as between junior and adult centres, and it seems clear that the present emphasis in adult centres on the creation of conditions approximating to those to be found in industry must involve a general departure from school hours and holidays. These conditions cannot be created satisfactorily otherwise.

43. Hours and holidays have a twofold importance. It is important to the mentally subnormal person that his life in the training centres should bear some resemblance, in its earlier years, to school life, and, later, to the working life of a normal adult. It is important to the staff that they enjoy appropriate conditions of service. It is probably not our business to make any recommendations about the conditions of service of the staff, but we must draw attention to the fact that the number and quality of staff required will not be recruited to this interesting and rewarding but by no means easy work unless such matters are properly considered by the authorities concerned.

Financial Implications

44. We are fully aware of the financial implications of our recommendations. They call for some expenditure of capital, e.g., on a Central College, but it is not difficult to visualise a number of ways in which this might be provided. They also call for a greatly increased level of annual expenditure. We have recommended that there should be courses of training lasting two years, and we see no reason why this recommendation should not be accepted. There is, however, no doubt that its full implementation depends on the willingness of local and hospital authorities to help staff to undertake these courses. Many authorities at present grant leave on full salary to student staff and pay their course fees and we think this should be the normal practice. Some give considerably less help. Adequate assistance is readily available for those entering training to become qualified teachers, and it seems to us reasonable that similar help should be extended to those training to teach the mentally subnormal. It is of cardinal importance that the employing authority should give adequate financial assistance to a student undertaking training, or satisfy itself that the local education authority will make a satisfactory grant. We urge the Ministry of Health to impress on the authorities their responsibility in this field.

45. Our recommendations have financial implications in addition to expenditure on capital projects and courses of training. One of their general effects would be to raise the level of training of the staff, partly as a result of recruitment of students with a higher initial level of education and partly as a result of the extra training we recommend, This higher level of training, and consequent higher status, calls for higher remuneration. Our terms of reference probably preclude any recommendation about salaries, but we state our view that our recommendations inevitably involve a re-examination of the salaries payable to the staff of the service, and in our opinion this re-examination must lead to higher salaries. Otherwise, as we have indicated earlier in our report in connexion with hours and holidays, the number and quality of staff required will not be secured. It would be unreasonable to expect to recruit them successfully.

Nomenclature

46. In general in our report we refer to the staff of training centres as teachers. We do so because that, in the main, is what they are. Nevertheless it is not the general practice to refer to them as teachers. The staff may have been awarded diplomas after successfully completing a course for " teachers of the mentally handicapped ". They may have spent years in a junior centre teaching mentally subnormal children. Yet they are usually referred to as supervisors and assistant supervisors, and we have therefore followed this practice to a certain extent in order to avoid confusion. We know that these staff are not yet eligible for recognition as teachers in the same way as teachers who have qualified after training for teaching in schools, but we do not regard this as a reason for denying them a name which aptly fits their function. Instructors in adult centres are not teachers in the same sense, and it would not be appropriate to call them teachers; and the senior member of the staff of an adult centre is probably best described as a manager. But the majority of other staff are in our view clearly teachers, and should be so called.

Special Care Units

47. A number of local health authorities have set up special care units, usually in association with junior training centres, and others have plans for doing so. These are usually in the form of an addition to the centre of an extra classroom with special toilet facilities, and generally arranged so that physically handicapped or incontinent children can be dealt with. We are aware that some of the units already in existence take adults as well as children.

48. The type of child taken varies considerably and includes those under the age normally placed in the nursery class, low grade children, and children who are trainable but for some reason, usually physical handicap, cannot easily be handled in the ordinary training group.

49. It is known that many low grade and physically handicapped children of all ages remain at home at their parents' wish, and it is important that some attempt should be made to provide help and relief for them, as well as for their children. The special care unit is one way of solving the problem, especially if it can be operated as part of a general plan which provides also for help and advice from welfare officers, short term residential care, hostel accommodation and appropriate treatment facilities. The variety of children and social situations is great, and there are other factors to be taken into account such as cost and geographical location. It may sometimes, therefore, be appropriate to rely primarily upon local authority services, and sometimes upon hospital services both in-patient and out-patient, and it may be necessary to consider also the development of day centres based upon the hospital. The balance of local health authority and hospital services in dealing with this problem will depend upon local conditions and local liaison.

50. Special care units are at present in too early a stage for it to be clear what their staffing implications might be. Much depends upon the type of child accepted, although it is our impression that the variety of children placed together in the units at present is sometimes too wide to allow of proper care

by the type of staff likely to be available. Staffing needs to be generous, and we think that nursery nurse trained staff can be of great assistance in this field. We cannot, however, foresee at the moment what developments may take place or at what speed, and we therefore make no recommendations about the recruitment and training of staff in special care units. We think, however, that local health authorities should be careful to employ staff appropriate to the type of person accepted, and, in particular, to ensure that they have training or experience sufficient to perceive the needs of those concerned, and to fulfil them. This cannot be done adequately without medical care and guidance.

II. THE NUMBER OF STAFF

Procedure

51. We were asked as part of our terms of reference to make an estimate of the number of staff required. We found this a matter of some difficulty owing to the number of factors of which there is little firm knowledge, but which must be taken into account if any reasonable estimate is to be made. We asked a number of questions in our questionnaire, and we made further enquiries to try to elucidate difficult points; and one of our members, Dr. Tizard, kindly made available the results of a research project.

52. We do not anticipate any difficulty in recruiting untrained assistants or escorts. We therefore confine ourselves to the two general grades of supervisors and instructors. We asked local health authorities and hospitals to estimate how many staff they would need in the three years commencing 1st January, 1960, and in Table 2 the numbers in post and required are shown.

Table 2

Numbers of Staff in Post at 1st January, 1960 and required in the Subsequent Three Years.

Grade	Local Health Authorities		Hospitals		Total	
	In Post	Required	In Post	Required	In Post	Required
Supervisor	348	153	64	17	412	170
Deputy and Assistant Supervisor	896	466	233	83	1,129	549
Trainee Supervisor....	63	231	—	12	63	243
Instructor	101	356	117	11	218	367
Total	1,408	1,206	414	123	1,822	1,329

53. Presumably supervisors and deputies will normally be appointed by promotion from within the service and this will cause further vacancies in some part of the service. We can consider all grades of supervisors together and it appears that local health authorities were intending to supplement their supervisory staffs by about 65% (1307 in post and 850 required), and hospitals by 38% (297 in post and 112 required). In total the expansion required was about 60% (1604 in post and 962 required). For instructors increases amounting to 3½ times those now employed were expected by local authorities.

54. How realistic these estimates are depends partly on the availability of staff and partly upon the fulfilment of capital building plans. In our questionnaire we asked employing authorities whether they were experiencing difficulty in recruiting staff. 25 local authorities and 16 hospital authorities said they were having great difficulty and a further 17 and 12 respectively said they were having some difficulty, the degree of difficulty being greater in counties than county boroughs and being concentrated in getting trained supervisors more than any other grade. There was apparently little difficulty in obtaining untrained supervisors or instructors. It seems unlikely that there would have been any considerable change in the situation since the date of our questionnaire, and we do not think it is likely that authorities are experiencing any real difficulty in filling posts, although they are obviously not able to fill them with trained personnel as they would wish.

55. It is hoped that, as appears at present to be the case, local health authorities' capital building plans will not be held up for lack of loan consents. The position is probably not so favourable in respect of hospital schools. There is some tendency, however, to be overoptimistic concerning the speed at which such plans can be completed and this often results in some overestimation of the need for staff.

56. Upon the basis of these figures it would appear that authorities wished to increase the number of supervisory staff by some 300 a year. In fact however, between 31st December, 1959, and 31st December, 1960, local authorities increased their whole-time staffs only by 219 altogether, according to the Ministry's returns (it is not possible to give a similar figure for hospitals). It is not clear whether in answering the questionnaire account was taken of wastage, which upon the replies given amounted to 191 per annum in all grades in the three years previous to 31st September, 1959. On the other hand, it may be that, as the effect of the building programme is felt, further staff will be required more rapidly, and this will be felt particularly in the demand for instructors. We think therefore that a more realistic figure for supervisors is in the region of 150-200 a year, and for instructors 75-100 and it would not be unreasonable to expect this expansion to continue, probably at a gradually increasing rate in the next few years.

57. If, however, we attempt to go beyond this the difficulties of estimation increase considerably. There are two methods of approach. In the first place we can work on the basis of the above figures taking into account probable future trends in expansion. There are a considerable number of junior centres needing

replacement and the provision of purpose built centres often leads to more places and some increase in staff. There are also a number of areas where initial provision is still awaited. There is certain to be considerable expansion in the provision of adult centres. There is a good age spread amongst the existing staff, and it would not seem that there will be any considerable difficulties over the numbers retiring. It is difficult to say, however, what effect our recommendations will have upon the proportion of married women (now 62%) since presumably the age of entry will tend to fall, and there will be more young married women with consequent wastage due to childbirth or upon marriage itself. However, it will be some time before these problems are likely to manifest themselves. On this basis, therefore, there may well be a gradual increase in the intake especially of instructors (see para. 79).

58. The other approach is to attempt to estimate how many staff there ought to be in the service on the basis of the number of the mentally subnormal. It is a common experience when centres are opened that children and adults come forward who for various reasons were not previously attending a centre. We thought this of sufficient importance to make a separate enquiry, and we therefore asked sixteen local health authorities who had recently opened new purpose built centres to analyse their intakes in the first year or part of a year up to 30th June, 1960. The number of centres covered was 5 junior and 29 junior/adult combined, opened in the period 3rd May, 1954, to 1st March, 1960. The analysis was as follows:

1.	Newly notified by the local education authority (including some admitted pending statutory examination)	228
2.	Newly notified by parents	12
3.	Parents previously refused to send their children	39
4.	Previously thought unsuitable by the local health authority	40
5.	Transport difficulties overcome	14
6.	From other local authority centres	49
7.	From other authorities	18
8.	From hospital	9
9.	Not specified	32
	Total new admissions	441

59. Even if we only take items 3, 4 and 5 amounting to 93 in all as being new admissions made possible by the provision of a proper centre, it is obvious there is a substantial element in these which is likely to increase the number of places required. The new centres taking only adults were too recently opened to make possible a separate analysis of admissions, but it seems likely that better arrangements for junior and adult training will increase the numbers coming forward for it. In addition there may be a number of over 16's in the community who are not known to local health authorities due to difficulties over ascertainment in the war years, and possibly to less effective ascertainment in previous years than there is now. We should like to draw the attention of local

authorities to the above and to urge them to take account of possible extra cases in planning their future provision. In hospitals there may be some increase in numbers as waiting lists are reduced, but it is doubtful whether these admissions will be of the type capable of benefiting from training.

The Prevalence of Mental Subnormality

60. There are about 27,000 mentally subnormal children on the registers of local health authorities in England and Wales. This is a rate of 2·44 per thousand, this figure including both children at home (18,700) and in hospitals (8,300).

61. Local authorities differ greatly in their ascertainment rates. It is clear from the results of research that the true prevalence of mental defect is considerably higher. The true prevalence of idiocy and imbecility alone is probably at least 3·60 per thousand* with perhaps an additional one per thousand "feebleminded" children, bringing the rate to an estimated 4·60 per 1,000.

62. Unfortunately no data are available for England and Wales as to the distribution of ascertained mentally subnormal children by age or grade. There are however some research results relating to Middlesex which has an ascertainment rate of 2·53 per 1,000 for children 0–16, only slightly higher than the national average. The age-specific rates for the County of Middlesex, by grade of mental defect, are given in Table 3.

Table 3

Age Specific Rates of Ascertained Mental Defect by Grade in Middlesex (1st January, 1960) with the Proportions in Hospital

Age Group	Idiots and Imbeciles	Feebleminded	Total	% in Hospital
0—4	0·92	0·07	0·99	25
5—9	2·69	0·33	3·02	26
10—14	2·83	0·78	3·61	40
0—14	2·13	0·40	2·53	33
5—14	2·76	0·57	3·33	38

63. In Table 4 the "ascertainment" rates obtained in Middlesex (population 2,300,000) have been applied to England and Wales, the following assumptions being made:

(*a*) That the proportion of children in each of the three age groups, in England and Wales as a whole, is much the same as it is in Middlesex —i.e. that the majority of children are not brought to notice till they

* A "true" prevalence rate of 3·60 idiots and imbeciles per thousand children aged 10–14 has been arrived at on the basis of a recent survey, carried out by Dr. Tizard with Miss N. Goodman, of Middlesex children.

are of school age and that substantial numbers remain in the educational system until they are seven to ten years of age.

(*b*) That the proportion of children with IQs. over 50—"feebleminded" children in the old terminology—in England and Wales is similar to that in Middlesex.

(*c*) That the proportion of children of different ages in hospital corresponds roughly to the Middlesex figures. (31% of ascertained defectives age 0—15 are in hospitals in England and Wales as compared with 33% in Middlesex.)

Table 4

Estimated "Administrative" Prevalence Rates of Mental Subnormality in England and Wales, based on Middlesex Rates

Age group	Population E. & W. (thousands)	Numbers of Mentally Subnormal		
		At home	In hospitals*	Total
0—4	3,452	2,684	733	3,417
5—9	3,282	7,699	2,213	9,912
10—15	4,317	10,230	5,354	15,584
Total 0—15	11,051	20,613	8,300	28,913
5—15	7,599	17,929	7,567	25,496

Estimated Number of Places required in Junior Centres

64. In England and Wales at the present time about 85% of mentally subnormal children living at home are estimated to be able to benefit from training at junior training centres. (The number of such children not in hospitals on the registers of local authorities is 18,700 of whom it is estimated that 16,325 are aged 5—15. Local authorities report that 13,774 children (85%) are either receiving training or could benefit from it.) An identical figure for London can be derived from the evidence submitted by the London County Council. In view of what has been said above this should be regarded as a minimum figure. It seems reasonable therefore to assume that places should be found for this proportion of children living at home.

65. Applying this rate to the "administrative" prevalence rates given in Table 4 suggests that something like 15,250 places in local authority junior training centres are needed at the present time. It should be noted that this figure is based on an "ascertained" prevalence rate of 3·33 per 1,000 children of school age, and not on an estimated true prevalence rate of 4·60 (including one per thousand "feebleminded" but excluding children attending schools for

* The numbers are based on Middlesex rates applied to the known total in England and Wales of approximately 8,300 in hospitals.

the educationally subnormal). The present ascertainment rate in some areas is considerably higher than the national average—London for example has 4·10 per thousand children aged 5—14 ascertained as mentally subnormal. Applying the London rates to England and Wales, the number of places required in local authority junior training centres would be 18,757, on the same assumptions.

66. For children in hospitals it is more difficult to make an estimate as to the numbers able to benefit from training. The proportion is unlikely to be less than fifty per cent, and may be more. If the figure of 50% is used the number of school age children in hospital who need training is 3,783. Thus the total number of trainable children both in hospitals and at home on the lower estimate is approximately 19,000. This figure takes no account of a number of complicating factors such as changes in the birth incidence and survival rates.

Estimated Number of Places required in Adult Centres

67. To assess the numbers of places required for adults in training centres is much more difficult than for children in that

(*a*) the ascertainment of adults is much less complete than that of children. No age specific figures are available.

(*b*) Some subnormal adolescents need sheltered employment on leaving schools for the educationally subnormal, and some "trainable" children become self-supporting on reaching adult life, or do not continue to attend the training centre.

(*c*) Changes in the expectation of life of the severely subnormal make long term forecasting difficult.

(*d*) The present ascertainment rates and the numbers officially considered as being suitable for training reflect existing shortages rather than the true needs. Thus the provision of places in adult occupation and industrial centres has increased from 2,529 in 1951 to 6,987 in 1959. During the same period the waiting list has increased from 3,886 to 7,191. That is, for each new place that has been created during the last ten years, nearly two defectives have been found who would benefit from being in it.

68. It was officially estimated that on 31st December, 1959, nearly 16,000 mentally subnormal adults needed training in local authority centres or in their own homes. Of these, 8,500 were receiving it, and 7,500 were awaiting training. It is not known to what extent the provision of additional places would stimulate further demands for them. Hence the true size of the problem today is unknown, and to forecast what the demand will be in five or ten years time is impossible. We do know, however, that even on today's official figures individual local authorities over the country as a whole must reckon to double their existing provision.

69. Ultimately the number of places in local authority centres for adults seems likely to rise to at least twice the number required for children, and possibly more. That is, about 30,000 places may be needed in day centres.

70. The number of adults in hospitals between sixteen and fifty-five years of age is about four-fifths of the total resident hospital population, or 44,000. (Appendix to Report of Royal Commission, 1954-57). Of these the great majority are capable of benefiting from some form of training. This is given in various ways in different hospitals—e.g., some patients work on the wards, and others on the grounds, while some are in workshops. The needs of these patients differ greatly, and hospital authorities have different policies in regard to employment and training.

71. The only information we know about how adult patients do in fact spend their time is that contained in a survey of patients in the Metropolitan area carried out in 1951-52*. The figures are summarised in Tables 5 and 6.

Table 5

Percentage of All Adult Patients in Hospitals (517) by Age and Grade

Age	Grade			Total
	Idiot	Imbecile	Feebleminded	
16—29	2	15	20	37
30—39	1	8	15	24
40—49	—	8	15	23
50+	—	8	8	16
Total	3	39	58	100

72. Table 5 gives the percentage of adult patients by age and grade of defect, on approximately 31st December, 1951. These percentages accord with the Registrar General's figures given in his survey of patients in mental deficiency institutions in England and Wales on 31st December, 1949;* but today the percentage of "feebleminded" adults may be smaller, and the age distribution may differ somewhat. There may well be further changes in the future.

73. In Table 6 the occupations are given for all adult in-patients at the time of the survey, the figures being expressed as percentages (*a*) of idiots and imbeciles; (*b*) of feebleminded patients.

* O'Connor and Tizard, B.M.J., 1954, 1, 16–18.

* Reg. Gen. Stat. Rev. Eng. and Wales, 1949. Supplement on General Morbidity, Cancer and Mental Health.

Table 6

Type of occupation	Per cent in each category of occupation		
	Idiots and Imbeciles N=277	Feebleminded N=240	Total N=517
Farm or garden	3	8	5
Domestic work	3	13	7
Labouring, messenger or laundry	5	9	7
School or occupation centre	8	4	6
Occupational therapy	7	8	8
Ward work	21	23	22
Hospital workshop	6	21	13
Unemployable	47	10	30
No information	—	4	2
	100	100	100

The table shows the range of occupations in hospitals at that time. It also indicates that more than half of the lower grade patients (fifty-three per cent) were " employable " in some way, and that ninety per cent of the feebleminded were employable.

74. Hospital policies have changed a good deal during the last ten years and more subnormal (i.e. feebleminded) patients are now being prepared for work in the community. The proportion in school and workshop is higher, and the proportion on the wards, or doing work round the hospital, is probably lower. But the ratio of feebleminded patients to imbeciles and idiots has probably fallen somewhat. Nevertheless we have reason to believe that although this analysis is ten years old it remains broadly applicable and we estimate that today perhaps one-third of adult mentally subnormal in-patients are unemployable, one-third are engaged in occupations in the wards or round the hospital under supervision of the nursing staff, and the remaining third are or should be in workshops or receiving other forms of training. If this is so, then there are, in hospitals for the mentally subnormal about 18,000 adults who require training.

The Number of Teaching Staff required in Junior Centres

75. The recommended staff/pupil ratio is one to ten. On the assumption that 19,000 places are required the number of teachers is 1,900 of whom 1,500 are needed by local authorities and 400 by hospitals. The present wastage figure is about 3% per annum, but it is likely to rise as the training system becomes stabilised owing to increased losses due to marriage, and to increased opportunity owing to higher qualification. The Ministry of Education estimate an annual 8·7% loss of women teachers who complete their training. On this basis to replace teachers leaving the service about 165 teachers would be required annually. Since there is likely to be wastage during training of perhaps 10%

the annual intake to replace existing staff would need to be about 180. On an estimate of 6% wastage the corresponding figures would be 114 and 125.

76. Because, as mentioned earlier, the "administrative" prevalence rate is likely to rise as services improve, these figures can only be regarded as tentative, and minimal, estimates. If the "administrative" prevalence rate for England and Wales rose to that of the London County Council the number of teachers required would be expanded by about one quarter; if it reached an estimated true prevalence rate of 4·6 per 1,000 the number would rise by 38%.

77. It will be seen that our estimates of teaching staff required, made independently by two different methods, differ to some extent. By the first method it was suggested that in the next three years an intake of 150—200 might be needed on an existing figure of 1,600, and it is further suggested above that on a figure of 1,900, 125—180 will be required. The former figures, however, allow for a good deal of expansion. On the other hand the figure of 19,000 places, is probably a minimum figure, since the numbers of the severely subnormal surviving to the relevant ages is apparently increasing. On the basis of the very inadequate information available it is difficult to give any more than a general figure, and we think our higher estimate is probably safer.

78. These estimates do not take into account provision for special care units. We do not think that the information available is sufficient to make an estimate on the above lines for these.

The Number of Staff required in Adult Centres

79. Ultimately the number of places required for adults in training centres as estimated above, may be as high as 48,000. It is likely, however, that it will be some time before the load approaches this and we think it wise to provide for a considerable and rising increase in the number of staff required. We have not found it possible to give any staff ratios for adult centres, nor can we predict what staff other than instructors will be needed. Our estimate of 75—100 each year for the next few years (para. 56) will need to suffice for the time being, with the proviso that the numbers required will probably in the long run be considerably larger.

Student Training Places required

80. We have not taken into account as yet, the number of existing staff who will require training. We have recorded our view that all those with ten years satisfactory service should be regarded as qualified, and those with between five and ten years, and those who already have another relevant training, might be considered by the Central Training Council for shortened courses. We have thus deliberately left a wide area of flexibility, and this makes estimation of the number of training places required for students somewhat hazardous. Most of the staff required for adult centres will be instructors and will require only a short course. Of the supervisors and deputy and assistant supervisors only 334 hold the National Association for Mental Health diploma. Even if one takes into account those who will be regarded as qualified if our recommendations

are accepted, (and this number will increase the longer their implementation is delayed) or who might take shorter courses, we think there will be a substantial number requiring the two-year training, probably not less than 500, and possibly rather more according to the number of exclusions.

81. We think there should be a target period over which authorities should aim to train all existing staff, but we recognise that only a limited number of experienced staff can be released each year in an expanding service, and that training of new recruits cannot be put off until existing staff have been trained. **We therefore recommend a period of ten years from the date of the first course as a period within which all staff employed at that date eligible for training should have received it.** It is hardly necessary to add that we should be very pleased if it could be done much more quickly; the period suggested should be an absolute maximum.

82. We are therefore thinking in terms of some 150—200 new recruits a year, and of training about 500 existing staff in the next ten years at the outside. The number of students per course needs to be small, with about 30 as the upper limit. Because of the high proportion of married women it is likely that a number of courses may need to be part-time for at least some of the period (although we think that this should not affect the gaining of all-round practical experience in a range of centres). There are also the considerable number of shorter courses to be organised. Even allowing for this it is reasonable to assume that the training of at least 150 new entrants to the service each year on courses lasting two years will involve at least five courses starting each year so that at the end of the first year ten courses would be running concurrently, five of them first year and five second. The training of some 500 workers already in post spread over ten years would involve places for about 50 each year. It may well be possible to train these workers in the same courses as the new entrants provided the courses are well distributed geographically. If so it would clearly help the people already established in the service to obtain training reasonably near their homes thus minimizing domestic inconvenience.

83. The ten two-year courses postulated will still leave room for some part-time courses to meet the needs of those who for domestic or other reasons are unable to devote two years to whole-time study. In addition there will be, we hope, the new courses we recommend for qualified teachers. We suggest this number of courses as a guide for preliminary planning on the assumption that the Central Training Council will be able to estimate the demand more accurately later on.

Summary of Main Recommendations and Conclusions applying both to local authority and hospital centres

84. (i) Authorities and staff should be made aware of the need for educational and psychological research on mental subnormality and should be encouraged to co-operate in, indeed to initiate, research whenever a suitable opportunity occurs (para. 17);

(ii) Courses of two years training should be provided in places

approved by a Central Training Council. This should be the main source of supply of teachers in training centres (para 22);

(iii) Arrangements should be made with an institute of education to provide, in association with other similar courses, one year supplementary courses for qualified teachers who wish to undertake teaching in training centres (para 24);

(iv) Consideration should be given by a Central Training Council to the introduction in a teacher training college of a specially designed experimental course lasting three years for unqualified staff (para. 25);

(v) Local and hospital authorities should give their staff every encouragement to take refresher courses (para. 27);

(vi) A residential Central College with research interests should be established and the two-year training courses we propose as our main recommendation should be provided there, among other places (para 28);

(vii) A student accepted for two-year training should normally have the General Certificate of Education with not less than three "O" level passes, one of which should be English Language (para. 29);

(viii) The minimum age of entry to a two-year course should be 18 years of age (para. 30);

(ix) Local and hospital authorities, perhaps in conjunction as may be locally convenient, should establish trainee schemes for school leavers between 16 and 18 years of age, with a day a week release for further education (para. 31);

(x) A Central Training Council should consider introducing suitable shorter courses for staff other than those undertaking two-year training, e.g. instructors in adult centres (paras. 33—35, 37);

(xi) Unqualified members of the teaching staff who have ten years experience and satisfactory service should be regarded as qualified (para. 34);

(xii) The establishment, maintenance and development of higher national standards of training should be supervised by a permanent independent body financed from public funds. A Central Council should be established for these purposes (para. 36);

(xiii) The Central Training Council should have an advisory staff of experts, who would keep in close touch with training centres (para. 38);

(xiv) The ratio of teaching staff to pupils in junior centres should be of the order of 1:10. Trainee teachers should be regarded as supernumerary (para. 39);

(xv) The supervisor of a centre, whether junior or adult, training upwards of 50 of the mentally subnormal should be free of responsibility for a group or class (para. 41);

(xvi) The employing authority should give adequate financial assistance to a student undertaking training, or satisfy itself that the local education authority will make a satisfactory grant (para. 44);

(xvii) A teaching staff of 1,900 with an annual intake of 150—200 teachers is required for junior centres (para. 77);

(xviii) An annual intake of 75—100 instructors is required for adult centres. This rate can be expected to increase (para. 79);

(xix) All staff employed at the date of the first course and eligible for training should have received it within ten years from that date (para. 81);

(xx) At least ten two-year courses will be required annually over the next ten years (para. 83).

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85. During our work we have been fortunate to receive admirable secretarial services, first from Dr. Gordon Rose, whom we co-opted to the Sub-Committee on his return to the University of Manchester, then from Mr. J. R. Brough and Mr. E. W. L. Keymer jointly, and finally from Mr. Keymer alone. In no merely formal sense we tender our warm thanks to them for their invaluable help.

86. We have also been fortunate in being able to call on the services of Mrs. W. M. Curzon of the Ministry of Health, formerly an Inspector of the Board of Control. Mrs. Curzon has put her extensive knowledge of the training centre service enthusiastically at our disposal and this has made her a most valuable contributor to the many discussions we have had in the course of our work. To her, too, we tender our warm thanks.

J. A. Scott (Chairman)
D. H. H. Thomas
Rose Cross
M. A. Davidson
B. Bushell
D. K. Drown
J. S. Hamilton
A. Josiffe
M. M. Lindsay
R. M. Marsh
A. G. Rose
J. Tizard

E. W. L. Keymer (Secretary)

September, 1961.

Bodies and Persons who gave Evidence

†Association of Hospital Management Committees.
Association of Municipal Corporations.
Association of Occupational Therapists.
Association of Teachers of the Mentally Handicapped.
British Council for the Welfare of Spastics.
†British Medical Association.
British Psychological Society.
County Councils Association.
†English Montessori Society (Northern Branch).
Guild of Teachers of Backward Children.
London County Council.
Middlesex County Council.
†Ministry of Education.
†Ministry of Labour.
National Association for Mental Health.
National Society for Mentally Handicapped Children.
*National Spastics Society.
National Union of Teachers.
Royal Medico-Psychological Association.
Society of Chief Administrative Mental Health Officers.
Society of Medical Officers of Health.
Special Schools Association.
†Women's Voluntary Service.
*Miss M. Brearley, Principal, The Froebel Educational Institute, Roehampton.
Miss R. D. Fidler, M.R.C.S., L.R.C.P., D.P.H., Senior Medical Officer, Middlesex County Council.
†Professor Herbert Goldstein, The Institute for Research on Exceptional Children, University of Illinois, U.S.A.
G. McCoull, Esq., O.B.E., V.R.D., M.D., Medical Superintendent, The Prudhoe and Monkton Hospital.
†Dr. N. Speyer, Chief Officer of Services for The Mentally Subnormal, The Hague, Holland.

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† Gave written evidence only.
* Gave oral evidence only.

Content of the Two Year Course for Teachers of Severely Subnormal Children in Junior Training Centres

The Sub-Committee would be going beyond its function if it laid down in precise detail the content and organisation of the proposed course. This will be the concern of whatever central body is appointed to be responsible for the training, and those in charge of the courses in different places, will no doubt, while following the main syllabus, develop individual ways of organisation and approach. We think, however, that it is appropriate for us to comment, in general, on what the syllabus should comprise, in the light of our own experience and judgment, and of the mass of advice from witnesses.

Aim and Scope of the Course

In our opinion the aim of the course should be to equip the students as teachers of severely mentally handicapped children, that is to give them such understanding and skill as will enable them to help the children in their charge to develop as fully as possible their physical, intellectual, social and practical skills and their powers of expression; to help them, too, to understand more clearly the world around them and to enable them to live in its as happily and competently as possible.

Since the word " training " is so much used in connection with centres for severely subnormal children we consider it of great importance that the students should, in their training, gain a very clear conception what education means, how it does not exclude useful training but, on the other hand, does not limit to training the teacher's task of aiding each severely subnormal child to develop his individual, independent, and unique pattern and tempo of growth.

In many ways, and in general outlook, we think the course should have much in common with teacher training courses, especially with those designed for infant and nursery school teachers. We are, however, convinced that the course should have a character and merits of its own, for in addition to a knowledge of normal child development and needs, the student should study the complexities of social behaviour and learning which arise in the severely subnormal group where mental and physical growth do not march together in the usual pattern of development found in more normal childhood. There is other information, too, not normally required in the ordinary teacher training course e.g., in the medical and psychological field. Moreover as their work may bring them into contact with other professional workers in the field of the severely subnormal we think students on the course should be given enough background knowledge to make communication between them and these other workers easy and fruitful in the interests of the children and their parents. We think, too, that students should be given more than ordinary help in learning to make good contact with parents and in appreciating the importance of his family to a child's happy development. Desirable for all teachers this has an added importance for teachers of severely subnormal children since they who need more than normal help from their homes add more than normal strains to family life.

We wish to emphasise the importance of the practical nature of the course. While students should be given a good foundation of the principles and theories of education and psychology, great care should be taken constantly to relate these to the actual problems of caring for, managing and teaching severely subnormal children. The medical, legal and administrative information should have a direct and helpful bearing on the teachers' work. We think that much of the study should be done in tutorial groups and that staffing should allow for this. There should be constant interaction between theory and practice and the arrangements for the teaching practice and observation should so far as possible be spaced to allow for this.

Actual teaching practice should, naturally, form an important part of the course; as well as group management and teaching practice and observation in local authority and hospital centres students at some stage in the course should have the experience of teaching, over a period, one severely subnormal child, since students find it difficult to do this while facing the problems of group management. It is important, too, that theory and practice should be in line with the best up to date practice in ordinary schools; students should have an opportunity of visiting these and we wish to underline the benefit they would gain from observation in good nursery and infant schools. At the same time they can benefit from visits to special schools and to schools for ordinary children at the secondary stage of education if only on being reminded of the sorts of activities and social demands suitable for the older children in the centres.

Visits to clinics, to welfare and employment offices etc. should also be included.

Students would greatly benefit from a period of residence with children, not necessarily handicapped.

The Curriculum—Subjects

In making suggestions about the subjects of the curriculum we recognise that in listing and analysing subject matter there is a danger that we may imply that the physical, intellectual, social and emotional growth of children can be treated in separate compartments. On the contrary we wish to emphasise that severely subnormal children like normal children react as whole persons in every type of living and learning situation. Nevertheless we think that some reference to divisions of subject matter may give emphasis and clarity to our suggestions. Broadly speaking, students should be given information and enlightenment in the following:—

Stages in normal child development; The importance of play.

The principles and practice of education (with relevant history of pioneer developments in education).

Psychology, particularly with maturation, learning, behaviour and the idea of mental growth in normal and handicapped children.

Child health and child care.

Medical aspects of subnormality.

Aspects of the relevant social services.

Students should have an opportunity of maintaining or extending their own general education, and it would be an advantage and personally enriching if they could follow some activity or study in depth, or do some independent task of investigation. We think it may be useful to speak in more detail of some aspects.

The importance of play in child development and learning; this should be given great emphasis since it has a particular relevance to children who are much slower than normal. In this field, as indeed in much of the principles of education, it is impossible to separate the educational and psychological aspects. It is important that the students should be made aware of how and why play is important socially, emotionally, and intellectually for children, but they must also be given practical help on how best to provide for good play in the environment and an understanding of the role of the adult in the play situation.

The development of speech and language—another fundamentally important subject where psychology and education meet and which is bound up, too, with play. Emphasis here should be on the kind of environment, activities and adult attitudes that promote in the children a desire to speak and help them to increasing skill in doing so rather than on the formal type of speech lessons so often given in training centres. In addition, however, students should learn why some children have difficulty in learning to speak beyond what one would expect even in severely subnormal children and they should be made aware of the special help that may be required from a psychiatrist or a speech therapist. This is not to overlook the value of good clear speech. Students may benefit from learning to listen to speech and to speak clearly and pleasantly themselves. They need particular help in learning how to communicate, in language, with children at very different levels of understanding of the spoken word.

Sensory experience—the basic importance of the sensory experience to learning requires much understanding. Students should learn what is meant by rich sensory experience and in the light of that knowledge study the question of " sense training " and become aware of how they can stimulate interest in these experiences and help the children to analyse and name the variations and patterns of their sense impressions. They should learn, too, of the ways in which some children are deprived in more or less degree of sense impression by deafness or defects of sight or by brain injury.

Among the range of subjects or activities that the teachers should be able to offer to children and in which they should, in the course, take an active part, are:—

Physical Education, including games, dancing and an understanding of the importance of movement in development; Music, including singing, rhythmic movement and use of percussion; Art and Craft including painting, modelling, weaving, sewing and simple woodwork; Housecraft for both boys and girls with the aim of providing not only simple skills in cooking, washing and cleaning, but a meaningful natural medium through which much hygiene and social training can be given. Nature Study, gardening and the study of the environment all enrich the lives of the children and themselves. Story-telling and simple dramatic work should be included.

Social training is much stressed in training centres. This is a more complex problem than the term suggests. Students should learn of the best ways of helping children to acquire good social habits, in fundamental daily activities and in considerate behaviour to others. They should learn how to judge when children are ready for more mature treatment than can be assessed by their apparent mental age. We think that the early habit training in control of the bowel and bladder, in washing and dressing and learning to behave well at table are as important functions of the teacher of the severely subnormal children as they are for the nursery school teacher and that the course should help students to understand the importance of these activities for personal growth and to appreciate the value for the teacher of contact with the children in that field of their learning.

It would be a good thing if students could discover just what social experiences severely subnormal children may or could be having outside the centre so that their teaching might be more realistically related to the child's experiences and opportunities.

Knowledge of individual and group management of children is important in social education. It is important that the teachers should be able to recognise what is involved in discipline and know what children of varying age, ability and temperament and adjustment can tolerate in the group situation or in personal control.

During the course the students should learn how to plan the day at the training centre, using the time to the best purpose; they should learn how to manage the learning situation, the place of individual and of group teaching, and how to observe and record behaviour and progress. They should also learn to select and use and make aids and to judge their value.

Reading and arithmetic. We should not expect these to be predominant subjects in the course. As, however, some of the older children in the centre may prove ready and able to profit from some teaching of every-day signs etc., we think that the students should learn what the activity of adult reading means and be given some practical insight on the ways in which children learn or are taught to read. Care should be taken to give the students a balanced view of the value of this activity in the centres lest they spend too much time on it at the expense of activities more useful for severely subnormal children. Any formal arithmetic is out of place in the training centre. There is need, however for the students to grasp how children acquire concepts of number, length and size and space and they should be given some knowledge of the latest theories and experiments in this field, particularly the work of Piaget though that would have to be carefully interpreted to them. For the older children practical use of money, recognition of time and simple measurement may be appropriate. We suggest that there is room for research here on what the children can and do use in ordinary life and that practice should be confined to the strictly useful.

Psychology. Much of this has been implicit in what has been said on other aspects of the curriculum. We repeat that its study should be confined to what helps the student to a better understanding of normal and subnormal children and that theory should be constantly related to facts which can be observed by the

students. They should learn about stages in development, about individual differences, and about the learning process, (and should be made aware here of present day experiments in the field of the subnormal). They should learn about behaviour, its normal variations and the usual causes of maladjustment and about motivation. They should learn something about the concept of mental growth and be given some insight into the purpose and value of mental testing.

Child Health and Care. General principles of child care. General hygiene including toilet and habit training. Planning the day; exercise, play, rest, meals, clothing, diet and general management of meals. Common ailments; infectious diseases; first aid. Public health services. Care of premises and equipment.

Medical Aspects of Mental Subnormality. Nature and causation of mental subnormality; anatomical, physiological, psychological and social deviations from the normal. Mongolism. Conditions which may be associated with mental subnormality, e.g., cerebral palsy, epilepsy, psychotic disorders, multiple handicaps, etc. Social implications, including family and community attitudes.

Aspects of the relevant Social Services. Administrative structure of the National Health Service. Historical development of Mental Health Services. The Mental Health Act, 1959, with special reference to provisions for the mentally subnormal. Other aspects of the social services.

History of the development of the care and education of the subnormal.

Finally while it is envisaged that a greater proportion of students will come to the course with a good background of education, and many of them straight from school, there may be need to include for some of the students some help in studying.

The above suggestions are mainly geared to the teaching in junior training centres. To some extent, however, the training centres for the adults will continue to provide an educative environment. The provision of workshops and the creation of an atmosphere of productivity does not exclude everything else. The physical, intellectual, social and emotional needs of the adult mentally subnormal will be better met if some of those responsible for their training are educators. (See paras. 19, 21 and 33).

Many of the educational activities in the adult training centre will grow from the specially designed programme in the last years at the junior centre, where we hope that more attention will be given to the preparation for the transfer to the adult centre. There will be little difficulty if the teachers and instructors each know something of the work of the other and if the two programmes are arranged so that the process of education, training and work is continuous.

To the extent that the training of teachers for junior centres is both general and must enable them to prepare the mentally subnormal for the transition to the adult centre, and in so far as teachers for adult centres must be able to continue some of the work of the junior centre, the course outlined above will be of value to teachers working in adult centres.

Appendix C

Tables of Information received in Reply to the Questionnaire

Analysis of the number of staff by employing authority at 31st December, 1959

Table 7*

Total Staff by Grade

Grade	County Borough Councils	County Councils	Total (Councils)	Hospitals	Grand total
Organiser	2	9	11	2	13
Supervisor	129	219	348	64	412
Deputy or Assistant Supervisor	382	514	896	233	1,129
Assistant or Training Assistant	23	42	65	4	69
Trainee or Trainee Supervisor ...	18	45	63	—	63
Instructor or Trainer					
Woodwork	14	10	24	13	37
Gardening	1	3	4	12	16
Boot Repairing	3	2	5	10	15
Handicraft	17	19	36	7	43
Laundry, Domestic, etc. ...	4	3	7	4	11
Other	16	9	25	71	96
Other Grades	46	120	166	79	245
Total	655	995	1,650	499	2,149

Table 8

Total Staff by the Number of Years in Post

Years in Post	County Borough Councils	County Councils	Total (Councils)	Hospitals	Grand total
Less than 1	99	199	298	88	386
1 and under 2	95	123	218	57	275
2 ,, ,, 3	55	99	154	56	210
3 ,, ,, 4	49	81	130	28	158
4 ,, ,, 5	47	104	151	19	170
5 ,, ,, 10	179	225	404	99	503
10 and over	93	128	221	123	344
Not stated	38	36	74	29	103
Total	655	995	1,650	499	2,149

* See Text for Tables 1–6.

Table 9

Total Staff by Sex

Sex	County Borough Councils	County Councils	Total (Councils)	Hospitals	Grand total
Male	112	81	193	145	338
Female	543	914	1,457	354	1,811
Total	655	995	1,650	499	2,149

Table 10

Total Staff by Age Group

Age Group	County Borough Councils	County Councils	Total (Councils)	Hospitals	Grand total
15—19	14	32	46	11	57
20—29	141	167	308	69	377
30—39	121	205	326	80	406
40—49	209	311	520	142	662
50—54	91	153	244	82	326
55—59	47	78	125	68	193
60—65	20	25	45	25	70
65 and over	6	5	11	9	20
Not stated	6	19	25	13	38
Total	655	995	1,650	499	2,149

Table 11

Total Staff by Marital Status

Marital Status	County Borough Councils	County Councils	Total (Councils)	Hospitals	Grand total
Single, Divorced, Separated ...	204	324	528	122	650
Married	396	583	979	356	1,335
Widowed	33	54	87	14	101
Not stated	22	34	56	7	63
Total	655	995	1,650	499	2,149

Table 12

Total Staff by Type of School Attended

Type of School	County Borough Councils	County Councils	Total (Councils)	Hospitals	Grand total
Elementary only	187	224	411	173	584
Secondary Grammar	175	283	458	103	561
Secondary Technical	23	29	52	11	63
Other Secondary					
Central or Senior	126	110	236	51	287
Private	28	27	55	8	63
Not known	57	203	260	101	361
Other	30	43	73	30	103
Not stated	29	76	105	22	127
Total	655	995	1,650	499	2,149

Table 13

Total Staff by Academic Qualification

Qualification	County Borough Councils	County Councils	Total (Councils)	Hospitals	Grand total
Ordinary G.C.E., less than 3 subjects	16	24	40	3	43
Ordinary G.C.E., 3 subjects ...	7	5	12	2	14
,, ,, 4 ,, ...	2	7	9	4	13
,, ,, 5 ,, ...	19	15	34	4	38
,, ,, more than 5 subjects	36	44	80	13	93
Advanced G.C.E., any number of subjects	2	3	5	4	9
University Degree	1	1	2	3	5
University Diploma, other than Social Science or Mental Health	1	—	1	2	3
Higher National or City and Guilds	18	11	29	5	34
Other	32	69	101	7	108
None stated	521	816	1,337	452	1,789
Total	655	995	1,650	499	2,149

Table 14

Total Staff by Specialist Qualification

Qualification	County Borough Councils	County Councils	Total (Councils)	Hospitals	Grand total
N.A.M.H. Diploma	121	206	327	36	363
Mental Nurse (R.M.P.A.,R.M.D.)	40	29	69	33	102
Nurse (S.R.N.,S.C.M.) (S.R.N. General)	21	24	45	2	47
Assistant Nurse (S.E.A.N.) ...	12	9	21	1	22
Nursery Nurse (N.N.E.B.) ...	31	29	60	4	64
Qualified Teacher	7	10	17	19	36
Qualified Teacher with E.S.N. Diploma	2	—	2	—	2
Recognised by Ministry of Education as Teacher of Mentally Deficient	2	2	4	—	4
Social Science Diploma (University)	—	3	3	—	3
Mental Health Diploma (P.S.W.)	—	9	9	—	9
Occupational Therapist	6	5	11	3	14
Domestic Science Diploma ...	1	1	2	2	4
Montessori	—	3	3	2	5
Trade Qualification	12	5	17	—	17
Margaret Morris (M.M.M.) ...	1	—	1	—	1
Child Care Reserve	5	2	7	1	8
Residential Child Care Certificate	3	8	11	—	11
Other	53	49	102	49	151
None stated	338	601	939	347	1,286
Total	655	995	1,650	499	2,149

Appendix D

Tables of Information received in Reply to the Questionnaire

Analysis of the Number of Supervisors by Employing Authority at 31st December, 1959

Table 15

Supervisors by the Number of Years in Post

Years in Post	County Borough Councils	County Councils	Total (Councils)	Hospitals	Grand total
Less than 1	6	4	10	7	17
1 and under 2	10	21	31	6	37
2 and under 3	4	16	20	8	28
3 and under 4	6	14	20	9	29
4 and under 5	7	17	24	3	27
5 and under 10	44	74	118	8	126
10 and over	46	72	118	20	138
Not stated	6	1	7	3	10
Total	129	219	348	64	412

Table 16

Supervisors by Sex

Sex	County Borough Councils	County Councils	Total (Councils)	Hospitals	Grand total
Male	26	17	43	13	56
Female	103	202	305	51	356
Total	129	219	348	64	412

Table 17

Supervisors by Age Group

Age Group	County Borough Councils	County Councils	Total (Councils)	Hospitals	Grand total
15—19	—	—	—	—	—
20—29	8	20	28	6	34
30—39	21	36	57	9	66
40—49	48	90	138	25	163
50—54	29	37	66	14	80
55—59	16	27	43	7	50
60—65	6	9	15	1	16
65 and over	1	—	1	—	1
Not stated	—	—	—	2	2
Total	129	219	348	64	412

Table 18

Supervisors by Marital Status

Marital Status	County Borough Councils	County Councils	Total (Councils)	Hospitals	Grand total
Single, Divorced, Separated ...	53	82	135	25	160
Married	67	115	182	34	216
Widowed	5	15	20	3	23
Not stated	4	7	11	2	13
Total	129	219	348	64	412

Table 19

Supervisors by the Type of School Attended

Type of School	County Borough Councils	County Councils	Total (Councils)	Hospitals	Grand total
Elementary only	35	39	74	15	89
Secondary Grammar	36	80	116	16	132
Secondary Technical	4	10	14	1	15
Other Secondary:					
Central or Senior	22	19	41	6	47
Private	9	7	16	2	18
Not known	10	39	49	11	60
Other	5	9	14	6	20
Not stated	8	16	24	7	31
Total	129	219	348	64	412

Table 20

Supervisors by Academic Qualification

Qualification	County Borough Councils	County Councils	Total (Councils)	Hospitals	Grand total
Ordinary G.C.E., less than 3 Subjects	—	1	1	—	1
Ordinary G.C.E., 3 subjects ...	—	—	—	—	—
,, ,, 4 ,, ...	—	1	1	1	2
,, ,, 5 ,, ...	5	2	7	—	7
,, ,, more than ... 5 subjects	6	11	17	2	19
Advanced G.C.E., any number of subjects	—	1	1	1	2
University Degree	1	—	1	—	1
University Diploma, other than Social Science or Mental Health	1	—	1	—	1
Higher National or City and Guilds	4	2	6	—	6
Other	6	17	23	2	25
None stated	106	184	290	58	348
Total	129	219	348	64	412

Table 21

Supervisors by Specialist Qualification

Qualification	County Borough Councils	County Councils	Total (Councils)	Hospitals	Grand total
N.A.M.H. Diploma	56	108	164	29	193
Mental Nurse (R.M.P.A., R.M.D.)	10	7	17	7	24
Nurse (S.R.N., S.C.M., S.R.N. General)	1	3	4	—	4
Assistant Nurse (S.E.A.N.) ...	1	2	3	1	4
Nursery Nurse (N.N.E.B.) ...	2	2	4	—	4
Qualified Teacher	4	3	7	—	7
Qualified Teacher with E.S.N. Diploma	—	—	—	—	—
Recognised by Min. of Ed. as Teacher of Mentally Deficient ...	—	—	—	—	—
Social Science Diploma (University)	—	—	—	—	—
Mental Health Diploma (P.S.W.)	—	8	8	—	8
Occupational Therapist	1	1	2	—	2
Domestic Science Diploma ...	—	—	—	—	—
Montessori	—	1	1	1	2
Trade Qualification	3	1	4	—	4
Margaret Morris (M.M.M.) ...	—	—	—	—	—
Child Care Reserve	—	—	—	—	—
Residential Child Care Certificate	—	2	2	—	2
Other	12	10	22	2	24
None stated	39	71	110	24	134
Total	129	219	348	64	412

Table 22

Supervisors with the N.A.M.H. Diploma by Age Group

Age Group	County Borough Councils	County Councils	Total (Councils)	Hospitals	Grand total
15—19	—	—	—	—	—
20—29	5	11	16	4	20
30—39	13	20	33	5	38
40—49	17	45	62	8	70
50—54	13	16	29	7	36
55—59	6	10	16	3	19
60—65	2	6	8	1	9
65 and over	—	—	—	—	—
Not stated	—	—	—	1	1
Total	56	108	164	29	193

Appendix E

Tables of Information received in Reply to the Questionnaire

Analysis of the Number of Deputy and Assistant Supervisors by Employing Authority at 31st December, 1959

Table 23

Deputy and Assistant Supervisors by the Number of Years in Post

Years in Post	County Borough Councils	County Councils	Total (Councils)	Hospitals	Grand total
Less than 1	55	125	180	52	232
1 and under 2	64	74	138	32	170
2 ,, ,, 3	42	62	104	28	132
3 ,, ,, 4	32	56	88	12	100
4 ,, ,, 5	34	64	98	10	108
5 ,, ,, 10	100	101	201	45	246
10 and over	39	30	69	42	111
Not stated	16	2	18	12	30
Total	382	514	896	233	1,129

Table 24

Deputy and Assistant Supervisors by Sex

Sex	County Borough Councils	County Councils	Total (Councils)	Hospitals	Grand total
Male	34	29	63	16	79
Female	348	485	833	217	1,050
Total	382	514	896	233	1,129

Table 25

Deputy and Assistant Supervisors by Age Group

Age Group	County Borough Councils	County Councils	Total (Councils)	Hospitals	Grand total
15—19	2	8	10	11	21
20—29	106	119	225	45	270
30—39	73	128	201	40	241
40—49	117	159	276	64	340
50—54	49	75	124	27	151
55—59	21	17	38	31	69
60—65	9	6	15	5	20
65 and over	1	2	3	6	9
Not stated	4	—	4	4	8
Total	382	514	896	233	1,129

Table 26

Deputy and Assistant Supervisors by Marital Status

Marital Status	County Borough Councils	County Councils	Total (Councils)	Hospitals	Grand total
Single, Divorced, Separated ...	112	151	263	59	322
Married	238	325	563	161	724
Widowed	23	27	50	11	61
Not stated	9	11	20	2	22
Total	382	514	896	233	1,129

Table 27

Deputy and Assistant Supervisors by the Type of School Attended

Type of School	County Borough Councils	County Councils	Total (Councils)	Hospitals	Grand total
Elementary only	97	118	215	63	278
Secondary Grammar	110	142	252	52	304
Secondary Technical	14	12	26	4	30
Other Secondary:					
Central or Senior	81	63	144	30	174
Private	17	11	28	5	33
Not known	31	118	149	55	204
Other	16	21	37	18	55
Not stated	16	29	45	6	51
Total	382	514	896	233	1,129

Table 28

Deputy and Assistant Supervisors by Academic Qualification

Qualification	County Borough Councils	County Councils	Total (Councils)	Hospitals	Grand total
Ordinary G.C.E., less than three subjects	14	11	25	2	27
Ordinary G.C.E., 3 subjects ...	5	4	9	2	11
,, ,, 4 ,, ...	1	3	4	2	6
,, ,, 5 ,, ...	11	9	20	4	24
,, ,, more than five subjects	26	22	48	8	56
Advanced G.C.E., any number of subjects	2	1	3	2	5
University Degree	—	—	—	1	1
University Diploma, other than Social Science or Mental Health	—	—	—	—	—
Higher National or City and Guilds	9	6	15	3	18
Other	14	36	50	2	52
None stated	300	422	722	207	929
Total	382	514	896	233	1,129

Table 29

Deputy and Assistant Supervisors by Specialist Qualification

Qualification	County Borough Councils	County Councils	Total (Councils)	Hospitals	Grand total
N.A.M.H. Diploma	57	78	135	6	141
Mental Nurse (R.M.P.A., R.M.D.)	24	17	41	10	51
Nurse, (S.R.N., S.C.N., S.R.N. General)	12	5	17	1	18
Assistant Nurse (S.E.A.N.) ...	8	7	15	—	15
Nursery Nurse (N.N.E.B.) ...	23	18	41	4	45
Qualified Teacher	5	7	12	3	15
Qualified Teacher with E.S.N. Diploma	—	5	5	—	5
Recognised by Min. of Ed. as Teacher of Mentally Deficient...	1	—	1	—	1
Social Science Diploma (University)	—	1	1	—	1
Mental Health Diploma (P.S.W.)	—	1	1	—	1
Occupational Therapist	3	—	3	—	3
Domestic Science Diploma ...	1	1	2	1	3
Montessori	—	—	—	1	1
Trade Qualification	2	—	2	—	2
Margaret Morris (M.M.M.) ...	1	—	1	—	1
Child Care Reserve	3	—	3	1	4
Residential Child Care Certificate	3	—	3	—	3
Other	29	—	29	15	44
None stated	210	374	584	191	775
Total	382	514	896	233	1,129

Table 30

Deputy and Assistant Supervisors with the N.A.M.H. Diploma by Age Group

Age Group	County Borough Councils	County Councils	Total (Councils)	Hospitals	Grand total
15—19	—	—	—	—	—
20—29	26	25	51	4	55
30—39	11	22	33	—	33
40—49	16	21	37	1	38
50—54	3	9	12	1	13
55—60	—	—	—	—	—
60—65	—	—	—	—	—
65 and over	—	—	—	—	—
Not stated	1	1	2	—	2
Total	57	78	135	6	141

Appendix F

Tables of Information received in Reply to the Questionnaire

Analysis of the Arrangements for Hours and Holidays by Employing Authority at 31st December, 1959

Table 31

Authorities by Type of Hours—Junior Centres

Hours	County Borough Councils	County Councils	Total (Councils)	Hospitals	Grand total
School	36	19	55	36	91
Other	2	1	3	8	11

Table 32

Authorities by Type of Hours—Junior/Adult Centres

Hours	County Borough Councils	County Councils	Total (Councils)	Hospitals	Grand total
School	39	30	69	12	81
Factory	1	—	1	3	4
Other	3	2	5	5	10

Table 33

Authorities by Type of Hours—Adult Centres

Hours	County Borough Councils	County Councils	Total (Councils)	Hospitals	Grand total
School	24	5	29	16	45
Factory	3	—	3	7	10
Other	5	—	5	5	10

Table 34

Authorities by Type of Holidays—Junior Centres

Holidays	County Borough Councils	County Councils	Total (Councils)	Hospitals	Grand total
School	34	21	55	12	67
Other	4	—	4	24	28

Table 35

Authorities by Type of Holidays—Junior/Adult Centres

Holidays	County Borough Councils	County Councils	Total (Councils)	Hospitals	Grand total
School	34	31	65	5	70
Other	9	—	9	17	26

Table 36

Authorities by Type of Holidays—Adult Centres

Holidays	County Borough Councils	County Councils	Total (Councils)	Hospitals	Grand total
School	14	3	17	4	21
Other	17	2	19	20	39

Appendix G

Table of Information received in Reply to the Questionnaire

Analysis of the Arrangements for Release on the N.A.M.H. Diploma Course by Employing Authority at 31st December, 1959

Table 37

Authorities by Release Arrangement

Release Arrangement	County Borough Councils	County Councils	Total (Councils)	Hospitals	Grand total
Leave; full salary and fees paid ...	28	18	46	31	77
Leave; ¾ salary and fees paid ...	11	3	14	—	14
Leave; less than ¾ salary and fees paid	5	5	10	—	10
Any of above without payment of fees	2	1	3	—	3
Local Education Authority Grants	4	7	11	2	13
Other arrangements	3	1	4	2	6

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